ASSOCIATION OF COMMUNITY CANCER CENTERS

FINANCIAL ADVOCACY NETWORK

OVERVIEW OF MEDICAID PROGRAM

Medicaid and CHIP provide health coverage to nearly 60 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities. In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. States can apply to CMS for a waiver of federal law to expand health coverage beyond these groups.

Many states have expanded coverage, particularly for children, above the federal minimums. For many eligibility groups, income is calculated in relation to a percentage of the Federal Poverty Level (FPL). For example, 100% of the FPL for a family of four is $22,350 in 2011. The Federal Poverty Level is updated annually. For other groups, income standards are based on income or other non-financial criteria standards for other programs, such as the Supplemental Security Income (SSI) program.

AFFORDABLE CARE ACT OF 2010 EXPANDS MEDICAID ELIGIBILITY IN 2014

The Affordable Care Act of 2010 creates a national Medicaid minimum eligibility level of 133% of the FPL ($29,700 for a family of four in 2011) for nearly all Americans under age 65. This Medicaid eligibility expansion goes into effect on January 1, 2014, but states can choose to expand coverage with Federal support anytime before this date, and some states have already done so.

OTHER ELIGIBILITY CRITERIA

There are other non-financial eligibility criteria that are used in determining Medicaid eligibility. In order to be eligible for Medicaid, individuals need to satisfy federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.

RETROACTIVE ELIGIBILITY

Medicaid coverage may start retroactively for up to three months prior to the month of application, if the individual would have been eligible during the retroactive period had he or she applied then. Coverage generally stops at the end of the month in which a person no longer meets the requirements for eligibility.

WAIVERS

States can apply to the Centers for Medicare & Medicaid Services (CMS) for waivers to provide Medicaid to populations beyond what traditionally can be covered under the state plan. Some states have additional “state only” programs to provide medical assistance for certain low-income people who do not qualify for Medicaid. No federal funds are provided for state only programs.

BENEFITS

States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory benefits," and can choose to provider other "optional benefits" through the Medicaid program. Here is a partial list of these benefits.

Mandatory Benefits

- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services
- Nursing facility services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Nurse Midwife services
- Transportation to medical care
- Tobacco cessation counseling for pregnant women.

Optional Benefits

- Prescription drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing, and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice.

PREMIUMS, CO-PAYMENTS & OTHER COST-SHARING

States have the option to charge premiums and to establish out-of-pocket spending (cost sharing) requirements for Medicaid enrollees. Out-of-pocket costs may include copayments, coinsurance, deductibles, and other similar charges. Maximum out of pocket costs are limited, but states can impose higher charges for targeted groups of somewhat higher income people. Certain vulnerable groups, such as children and pregnant women, are exempt from most out-of-pocket costs, and copayments and coinsurance cannot be charged for certain services.

States can charge limited premiums and enrollment fees on the following groups of Medicaid enrollees:

- Pregnant women and infants with family income at or above 150% FPL.
- Qualified disabled and working individuals with income above 150% FPL.
- Disabled working individuals eligible under the Ticket to Work and Work Incentives Improvement Act of 1999.
- Disabled children eligible under the Family Opportunity Act.
- Medically needy individuals.

States have the option to impose higher, alternative premiums on other groups of enrollees, if their family incomes exceed 150% of the FPL. Certain groups, such as institutionalized individuals and most children, are excluded from higher cost sharing.

PRESCRIPTION DRUGS

Medicaid rules give states the ability to use out-of-pocket charges to promote the most cost-effective use of prescription drugs. To encourage the use of lower-cost drugs, states may establish different copayments for generic versus brand-name drugs or for drugs included on a preferred drug list. For people with incomes above 150% FPL, copayments for non-preferred drugs may be as high as 20 percent of the cost of the drug. For people with income at or below 150% FPL, copayments are limited to nominal amounts. States must specify which drugs are considered either "preferred" or "non-preferred." States also have the option to establish different copayments for mail order drugs and for drugs sold in a pharmacy.

GLOSSARY

Spousal Impoverishment: Protects the spouse still living in the community from becoming impoverished when the other spouse enters a nursing facility or other medical institution and is expected to remain there for at least 30 days.

Treatment of Trusts: When an individual, their spouse, or anyone acting on the individual's behalf establishes a trust using at least some of the individual's funds, that trust can be considered available to the individual for purposes of determining eligibility for Medicaid.

Transfers of Assets for Less Than Fair Market Value: This practice is prohibited for purposes of establishing Medicaid eligibility. Applies when assets are transferred, sold, or gifted for less than they are worth by individuals in long-term care facilities or receiving home and community-based waiver services, by their spouses, or by someone else acting on their behalf.

Estate Recovery: State Medicaid programs must recover from a Medicaid enrollee's estate the cost of certain benefits paid on behalf of the enrollee, including nursing facility services, home and community-based services, and related hospital and prescription drug services. State Medicaid programs may recover for other Medicaid benefits, except for Medicare cost-sharing benefits paid on behalf of Medicare Savings Program beneficiaries.

Third-Party Liability: TPL refers to third parties who have a legal obligation to pay for part or all of the cost of medical services provided to a Medicaid beneficiary. Examples are other programs such as Medicare, or other health insurance the individual may have that covers at least some of the cost of the medical service. If a third party has such an obligation, Medicaid will only pay for that portion.